Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

April 7, 2026

Licensee
Benedict House
3883 19th Avenue Northwest
Rochester, MN 55901

RE: Project Number(s) SL32176016

Dear Licensee:

On December 23, 2025, the Minnesota Department of Health completed a follow-up survey of your facility to determine correction of orders from the survey completed on October 1, 2025. This follow-up survey verified that the facility is in substantial compliance.

You are encouraged to retain this document for your records. It is your responsibility to share the information contained in the letter with your organization's Governing Body.

Please feel free to call me with any questions.

Sincerely,

Stephanie Jones de Palma, Supervisor
State Evaluation Team
Email: stephanie.jones.de.palma@state.mn.us
Telephone: 651-201-4320 Fax: 1-866-890-9290

HHH

Electronically Delivered

October 29, 2025

Licensee
Benedict House
3883 19th Avenue Northwest
Rochester, MN 55901

RE: Project Number(s) SL32176016

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on October 1, 2025, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, MDH noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

STATE CORRECTION ORDERS

The enclosed State Form documents the state correction orders. MDH documents state licensing correction orders using federal software. Tag numbers are assigned to Minnesota state statutes for Assisted Living Facilities. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute number and the corresponding text of the state statute out of compliance are listed in the "Summary Statement of Deficiencies" column. This column also includes the findings that are in violation of the state statute after the statement, "This MN Requirement is not met as evidenced by . . ."

IMPOSITION OF FINES

In accordance with Minn. Stat. § 144G.31, Subd. 4, fines and enforcement actions may be imposed based on the level and scope of the violations and may be imposed immediately with no opportunity to correct the violation first as follows:

Level 1: no fines or enforcement;
Level 2: a fine of $500 per violation, in addition to any enforcement mechanism authorized in § 144G.20;
Level 3: a fine of $1,000 per incident, in addition to any enforcement mechanism authorized in § 144G.20;
Level 4: a fine of $3,000 per incident, in addition to any enforcement mechanism authorized in § 144G.20;
Level 5: a fine of $5,000 per violation, in addition to any enforcement mechanism authorized in § 144G.20.

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, the following fines are assessed

pursuant to this survey:

St - 0 - 0510 - 144g.41 Subd. 3 - Infection Control Program - $500.00
St - 0 - 0775 - 144g.45 Subd. 2. (a) - Fire Protection And Physical Environment - $1,000.00

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, **the total amount you are assessed is $1,500.00**. You will be invoiced approximately 30 days after receipt of this notice, subject to appeal.

DOCUMENTATION OF ACTION TO COMPLY
In accordance with Minn. Stat. § 144G.30, Subd. 5(c), the licensee must document actions taken to comply with the correction orders within the time period outlined on the state form; however, plans of correction are not required to be submitted for approval.

The correction order documentation should include the following:

- Identify how the area(s) of noncompliance was corrected related to the resident(s)/employee(s) identified in the correction order.
- Identify how the area(s) of noncompliance was corrected for all of the provider's resident(s)/employees that may be affected by the noncompliance.
- Identify what changes to your systems and practices were made to ensure compliance with the specific statute(s).

CORRECTION ORDER RECONSIDERATION PROCESS
In accordance with Minn. Stat. § 144G.32, Subd. 2, you may challenge the correction order(s) issued, including the level and scope, and any fine assessed through the correction order reconsideration process. The request for reconsideration must be in writing and received by MDH within 15 calendar days of the correction order receipt date.

To submit a reconsideration request, please visit:
https://forms.web.health.state.mn.us/form/HRDAppealsForm

REQUESTING A HEARING
Alternatively, in accordance with Minn. Stat. § 144G.31, Subd. 5(d), an assisted living provider that has been assessed a fine under this subdivision has a right to a reconsideration or a hearing under this section and chapter 14. Pursuant to Minn. Stat. § 144G.20, Subd. 14 and Subd. 18, a request for a hearing must be in writing and received by the Department of Health within 15 business days of the correction order receipt date. The request must contain a brief and plain statement describing each matter or issue contested and any new information you believe constitutes a defense or mitigating factor.

To submit a hearing request, please visit:
https://forms.web.health.state.mn.us/form/HRDAppealsForm

To appeal fines via reconsideration, please follow the procedure outlined above. Please note that you may request a reconsideration **or** a hearing, but not both. If you wish to contest tags without fines in a reconsideration and tags with the fines at a hearing, please submit two separate appeals forms at the website listed above.

The MDH Health Regulation Division (HRD) values your feedback about your experience during the survey and/or investigation process. Please fill out this anonymous provider feedback questionnaire at your convenience at this link: **https://forms.office.com/g/Bm5uQEpHVa**. Your input is important to us and will enable MDH to improve its processes and communication with providers. If you have any questions regarding the questionnaire, please contact Susan Winkelmann at susan.winkelmann@state.mn.us or call 651-201-5952.

You are encouraged to retain this document for your records. It is your responsibility to share the information contained in the letter and state form with your organization's Governing Body.

If you have any questions, please contact me.

Sincerely,

Jodi Johnson, Supervisor
State Evaluation Team
Email: Jodi.Johnson@state.mn.us
Telephone: 507-344-2730 Fax: 1-866-890-9290

HHH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	32176	A. BUILDING: _____ B. WING _____	10/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BENEDICT HOUSE	3883 19TH AVE NW ROCHESTER, MN 55901

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 000	Initial Comments *****ATTENTION***** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER(S) In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a survey. Determination of whether violations are corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: SL32176016-0 On September 29, 2025, through October 1, 2025, the Minnesota Department of Health conducted a full survey at the above provider and the following correction orders are issued. At the time of the survey, there were 15 residents; 15 receiving services under the Assisted Living Facility with Dementia Care license.	0 000	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living Facilities. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the evaluators ' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.	
0 480 SS=F	144G.41 Subdivision 1 Subd. 1a (a-b) Minimum requirements; required food services	0 480		

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0 480	Continued From page 1 (a) Except as provided in paragraph (b), food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626. (b) For an assisted living facility with a licensed capacity of ten or fewer residents: (1) notwithstanding Minnesota Rules, part 4626.0033, item A, the facility may share a certified food protection manager (CFPM) with one other facility located within a 60-mile radius and under common management provided the CFPM is present at each facility frequently enough to effectively administer, manage, and supervise each facility's food service operation; (2) notwithstanding Minnesota Rules, part 4626.0545, item A, kick plates that are not removable or cannot be rotated open are allowed unless the facility has been issued repeated correction orders for violations of Minnesota Rules, part 4626.1565 or 4626.1570; (3) notwithstanding Minnesota Rules, part 4626.0685, item A, the facility is not required to provide integral drainboards, utensil racks, or tables large enough to accommodate soiled and clean items that may accumulate during hours of operation provided soiled items do not contaminate clean items, surfaces, or food, and clean equipment and dishes are air dried in a manner that prevents contamination before storage; (4) notwithstanding Minnesota Rules, part 4626.1070, item A, the facility is not required to install a dedicated handwashing sink in its existing kitchen provided it designates one well of a two-compartment sink for use only as a handwashing sink; (5) notwithstanding Minnesota Rules, parts 4626.1325, 4626.1335, and 4626.1360, item A, existing floor, wall, and ceiling finishes are	0 480		

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0 480	Continued From page 2 allowed provided the facility keeps them clean and in good condition; (6) notwithstanding Minnesota Rules, part 4626.1375, shielded or shatter-resistant lightbulbs are not required, but if a light bulb breaks, the facility must discard all exposed food and fully clean all equipment, dishes, and surfaces to remove any glass particles; and (7) notwithstanding Minnesota Rules, part 4626.1390, toilet rooms are not required to be provided with a self-closing door. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure food was prepared and served according to the Minnesota Food Code. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: Please refer to the document titled, Food and Beverage Establishment Inspection Report (FBEIR) dated September 29, 2025, for the specific Minnesota Food Code violations. The Inspection Report was provided to the licensee within 24 hours of the inspection.	0 480		

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0 480	Continued From page 3 TIME PERIOD FOR CORRECTION: Please refer to the FBEIR for any compliance dates.	0 480		
0 510 SS=F	144G.41 Subd. 3 Infection control program (a) All assisted living facilities must establish and maintain an infection control program that complies with accepted health care, medical, and nursing standards for infection control. (b)The facility's infection control program must be consistent with current guidelines from the national Centers for Disease Control and Prevention (CDC) for infection prevention and control in long-term care facilities and, as applicable, for infection prevention and control in assisted living facilities. (c) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to establish and maintain an effective infection control program that complies with accepted health care, medical and nursing standards for infection control related to glove use and handwashing by two of three unlicensed personnel (ULP-D, ULP-F) during blood sugar testing, medication administration and personal cares. This had the potential to affect all residents, staff and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic	0 510		

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0 510	Continued From page 4 failure that has affected or has potential to affect a large portion or all of the residents). The findings include: BLOOD SUGAR TESTING On September 29. 2025, at 11:30 a.m., the surveyor observed ULP-D to conduct R1's blood sugar check at the dining room table. ULP-D donned gloves, placed the blood sugar testing equipment directly on the dining room table, wiped R1's finger with an alcohol wipe, poked R1's finger obtaining a drop of blood applied it to the blood sugar test strip and inserted the strip into the monitor sitting on the table. ULP-D used the alcohol wipe to rewipe R1's finger after the blood was obtained, and gathered the equipment from the dining table, discarded the test strip and lancet (used to poke finger) into the sharps container, removed her gloves and sanitized her hands. ULP-D completed a blood sugar check at the dining room table, failed to provide a barrier between the blood testing equipment and the tabletop, and failed to wipe the table area where the testing equipment sat before lunch was served. On September 30, 2025, at 7:15 a.m., the surveyor observed ULP-D check R5's blood sugar in R5's room. ULP-D donned gloves, obtained a blood sugar from R5, gathered the blood sugar testing equipment and left R5's room. While returning to the medication cart, ULP-D closed and locked a kitchen half door (with the same gloves used for blood sugar testing) and then disposed of the blood sugar testing strip and lancet to the sharps container. Still using the same gloves, ULP-D used her keys to open the medication cart and placed R5's blood sugar	0 510		

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0 510	Continued From page 5 testing equipment in the top drawer of the cart. ULP-D then closed and locked the cart, removed her gloves, disposed of them and sanitized her hands. ULP-D failed to ensure she removed her gloves and sanitized her hands following a blood sugar check and before touching other surfaces. On September 30, 2025, at 7:46 a.m., the surveyor observed ULP-D set up and administer R3's medications. ULP-D then donned gloves, checked R3's blood sugar and then with the same gloves, administered R3's insulin injection. With the same gloves on, ULP-D gathered the blood testing equipment, lancet, used blood testing strip, and R3's reusable insulin auto injector pen and returned to the medication cart. ULP-D disposed of the blood testing strip, pen needle tip into the sharps container, used her keys to unlock and open the medication cart and returned the blood testing equipment and insulin auto-injector to R3's section of the medication cart. ULP-D failed to remove her gloves after obtaining a blood sample for R3's blood sugar check and before managing her insulin injection, returning blood testing supplies, insulin pen, and before contact with other surfaces (keys and medication cart drawer). On September 30, 2025, at 11:40 a.m., the surveyor observed ULP-F to conduct R1's blood sugar check at the dining room table. ULP-F donned gloves, placed the blood sugar testing equipment directly on the dining room table, wiped R1's finger with an alcohol wipe, poked R1's finger obtaining a drop of blood applied it to the blood sugar test strip and inserted the strip into the monitor sitting on the table. ULP-F used the alcohol wipe to rewipe R1's finger after the blood was obtained, and gathered the equipment from the dining table, discarded the test strip	0 510		

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0 510	Continued From page 6 removed her gloves and returned the equipment to the medication cart. Without washing her hands, ULP-F assisted another resident to ambulate to the dining room table and managed other tasks preparing for lunch. ULP-F failed to provide a barrier between the blood testing equipment and the tabletop, failed to wipe the table before lunch was served, and failed to sanitize her hands after removing her gloves, before touching other surfaces or having direct contact with other residents. PERSONAL CARES AND MEDICATION ADMINISTRATION On September 30, 2025, at 8:30 a.m., the surveyor observed ULP-D and ULP-F don gloves and assist R8 with sitting up in bed, transferred R8 with an EZ-Stand (mechanical lift), to the bathroom toilet. ULP-F assisted R8 to remove her wet incontinence brief and remove her wet pajamas. ULP-F removed and discarded her gloves, donned a clean set of gloves, assisted R8 with changing her pajama top to a blouse, combed her hair, and placed a clean incontinence brief and clean pants on. ULP-D and ULP-F then assisted R8 with placement of the EZ stand sling and raised R8 to a standing position with the stand. ULP-F wiped R8's bottom with a wet wipe, fastened a clean brief and pulled up R8's pants. ULP-D and ULP-F transferred and lowered R8 to her wheelchair. ULP-F continued to use the same gloves with manipulating the EZ stand and R8's wheelchair. ULP-F removed her gloves and without washing her hands, wheeled R8 to the dining room table. ULP-F then moved on to the medication cart, set up and administered R8's medications and documented cares and medication administration. ULP-F then moved	0 510		

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0 510	Continued From page 7 onto setting up another resident's medications for administration without sanitizing her hands. On September 30, 2025, at 9:04 a.m., the surveyor observed ULP-F complete contact with R8 and without sanitizing her hands, move on to set up and administer R9's mediations. ULP-F administered R9's oral medications and then donned gloves to administer eye drops. ULP-F returned to the medication cart, removed her gloves and documented R9's medication administration. Following documentation, ULP-F moved onto R2's medication set up. On September 30, 2025, at 9:16, a.m., the surveyor observed ULP-F complete contact with R9 and without sanitizing her hands, set up and administered R2's oral medications, and donned gloves to assist with R2's topical pain medication. ULP-F returned to the medication cart, removed her gloves and without sanitizing her hands, returned equipment to the medication cart and documented R2's medication administration on the tablet. On September 30, 2025, at 9:25 a.m., the surveyor observed ULP-F to move onto set up and administer R6's medications. Following medication administration, ULP-F assisted R6 with adjusting her blanket and returned to the medication cart to document the medication administration. No hand sanitizing was observed before or after resident contact. On September 30, 2025, at 9:28 a.m., the surveyor observed ULP-F move on from documenting the previous medication administration at the medication cart, to gather equipment to check R8's blood pressure. ULP-F checked R8's blood pressure, wiped the	0 510		

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0 510	Continued From page 8 equipment with a disinfecting wipe, returned the equipment to the basket, and documented vital signs results on the computer. ULP-F failed to properly sanitize hands following glove use with personal cares, medication administration, and before and following direct contact with several residents. On October 1, 2025, at 1:00 p.m., clinical nurse supervisor (CNS)-B stated staff should not be conducting blood sugar checks at the dining room table, but instead away from the table, or in the resident's room. She further stated staff are taught to remove their gloves and sanitize hands immediately following tasks such as conducting a blood sugar check, after changing incontinence briefs and between resident contact. The licensee's Procedure for Using Gloves policy dated March 3, 2022, indicated gloves are to be worn whenever there may be direct contact between the caregiver's hands and blood, body fluids, secretions, feces, or a contaminated item, such as soiled linens or wound dressings. Gloves will be removed carefully and disposed of in a proper container. Rewash hands. The licensee's Hand Hygiene policy dated March 3, 2022, indicated Handwashing, which is the single most effective way of controlling the spread of infection, will be performed by staff routinely and thoroughly to protect residents from the spread of infection. PROCEDURE 1. When Hands Should be Washed. Hand washing shall be performed between client cares and whenever direct physical contact with a client takes place. Use of gloves does not replace hand	0 510		

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0 510	Continued From page 9 washing. Hands should be washed or decontaminated: a. Before and after direct contact with a client b. If moving from a contaminated-body site to a clean-body site during client care c. After contact with environmental surfaces or equipment in the immediate vicinity of the client d. After removing gloves or gowns e. Before eating and after using a restroom No other information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 510		
0 700 SS=F	144G.43 Subdivision 1 Resident record (b) Resident records, whether written or electronic, must be protected against loss, tampering, or unauthorized disclosure in compliance with chapter 13 and other applicable relevant federal and state laws. The facility shall establish and implement written procedures to control use, storage, and security of resident records and establish criteria for release of resident information. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure residents' personal health and medical information was kept private. This had the potential to affect all 15 residents. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a	0 700		

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0 700	Continued From page 10 widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: On September 29, 2025, between 11:30 a.m. and 12:00 p.m., and September 30, 2025, between 6:45 a.m. and 11:30 a.m., the surveyor conducted observations of medication administration, treatments and cares completed by the unlicensed personnel (ULP). During this time, the surveyor observed two electronic tablets, one found on each medication cart (north side, south side), used by the ULP to access resident medications, treatments and tasks. The surveyor observed both tablet screens with resident information always open and visible to others (other residents, non-clinical staff, and visitors), when not in use. On October 1, 2025, at 2:00 p.m., regional director of housing services (RDHS)-C stated she too had noted the open screens when she walked through the facility and had minimized the screens to ensure confidentiality. RDHS-C further stated the licensee would work with staff to find a consistent practice of managing the tablet's screens to ensure no resident information was visible to others. The licensee's Security of Resident's Records policy dated March 3, 2022, indicated resident records will be kept secure and protected against loss, tampering, or unauthorized disclosure and in accordance with applicable legal requirements and existing [licensee name] policies. No further information was provided.	0 700		

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	32176	A. BUILDING: _____ B. WING _____	10/01/2025

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0 700	Continued From page 11 TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 700		
0 775 SS=I	144G.45 Subd. 2. (a) Fire protection and physical environment Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and: This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to maintain facility in compliance with Minnesota State Fire Code under Minnesota Rules Chapter 7511. This had the potential to affect some residents, staff, and visitors. This practice resulted in a level three violation (a violation that harmed a resident's health or safety, or a violation that had the potential to cause more than minimal harm to the resident) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On September 30, 2025, from approximately 12:20 p.m. to 2:35 p.m., the surveyor toured the facility with environmental services director (ESD)-G, maintenance lead (ML)-J and regional director of environmental services (RDES)-K. During the tour the surveyor observed the following: The exit doors in the Northwest corner of the	0 775		

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0 775	Continued From page 12 facility and in the Southwest corner of the facility were labeled as delayed egress doors with signage reading "PUSH UNTIL ALARM SOUNDS DOOR CAN BE OPENED IN 15 SECONDS." Upon testing by ESD-G, ML-J and the surveyor it was discovered that the doors do not unlock when the panic hardware is pressed down for 15 seconds. When the push bar was activated, the door began beeping but remained locked. The delayed egress functionality of the door was not functional, and the door operated as a controlled egress door. RDES-K provided information from the Rochester Fire Marshal's Office regarding the door which indicated the door had been reviewed to ensure it tied in with the fire alarm panel, sprinkler system and remote release button. The surveyor contacted the Rochester Fire Marshal who confirmed that the signage indicating delayed egress should not be present on the doors if they do not open after being pushed for 15 seconds. The signage on the Northwest and Southwest doors should be removed, or the functionality of the delayed egress doors should be restored. Signage about an exit door should not be misleading and inaccurate. ESD-G and RDES-K acknowledged that the signage on the doors is not accurate. The exit door in the Southwest corner also had a fabric banner with a stop sign on it obscuring and obstructing the exit door. The banner should be removed, and all exit doors should be maintained free of obstruction. From the back hallway near the loading dock and laundry room, the marked exit pathway directed occupants to exit through controlled egress doors to enter the North or South of the hallway out into the corridors, and then through a second set of controlled egress doors. An occupant of the building in this hallway would need to pass through two controlled egress doors before	0 775		

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0 775	Continued From page 13 exiting. A building occupant shall not be required to pass through more than one door equipped with a controlled egress lock before entering an exit. The shrubbery near the fire department connection (FDC) was significantly overgrown making fire department access difficult. The FDC should be maintained accessible and free of obstruction. Rated fire doors were propped open in the pantry hallway area near the staff lounge and mechanical closet. The doors were propped open with wooden doorstops on either end of the hallway. Fire doors should be maintained free of obstruction so that they properly close and latch during an emergency to prevent spread of smoke or flame. Lint had accumulated behind the clothes dryer in the laundry room. This accumulation of lint may pose a fire hazard and should be removed and dryer ventilation maintained in proper working order to prevent lint build up. A fire rating placard was painted over on a fire rated door leading to the nurse's office. The paint was removed by ESD-G and ML-J during survey. RDES-K acknowledged the noted deficiencies during the tour and expressed that they would correct the deficiencies. TIME PERIOD FOR CORRECTION: Two (2) days	0 775		
0 790 SS=B	144G.45 Subd. 2 (a) (2-3) Fire protection and physical environment	0 790		

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0 790	Continued From page 14 (2) install and maintain portable fire extinguishers in accordance with the State Fire Code; (3) install portable fire extinguishers having a minimum 2-A:10-B:C rating within Group R-3 occupancies, as defined by the State Fire Code, located so that the travel distance to the nearest fire extinguisher does not exceed 75 feet, and maintained in accordance with the State Fire Code; and This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to maintain the portable fire extinguishers. This deficient condition had the potential to affect all staff, residents, and visitors. This practice resulted in a level one violation (a violation that will cause only minimal impact on the client and does not affect health or safety) and was issued at a pattern scope (when more than a limited number of clients are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: On September 30, 2025, from approximately 12:20 p.m. to 2:35 p.m., the surveyor toured the facility with environmental services director (ESD)-G, maintenance lead (ML)-J and regional director of environmental services (RDES)-K. During the tour the surveyor observed the following:	0 790		

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0 790	Continued From page 15 A fire extinguisher was provided in the mezzanine attic area which had an annual service tag indicating servicing in January of 2025. There was one monthly inspection completed and recorded on the back of the tag completed on January 27, 2025. All other extinguishers had current monthly staff inspections. ESD-G stated that staff likely forgot about servicing this extinguisher due to its remote location, but that it would be addressed, and the extinguisher would be regularly inspected. All extinguishers should be visually inspected by staff each month and recorded to ensure extinguishers are in proper working order. During the tour and interview, ESD-G acknowledged the deficiency and stated that staff would ensure regular inspections on all extinguishers. TIME PERIOD FOR CORRECTION: Seven (7) days.	0 790		
0 800 SS=E	144G.45 Subd. 2 (a) (4) Fire protection and physical environment (4) keep the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents in accordance with a maintenance and repair program. This MN Requirement is not met as evidenced by:	0 800		

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0 800	Continued From page 16 Based on observation and interview, the licensee failed to provide the physical environment in a continuous state of good repair and operation with regard to the health, safety, and well-being of the residents. This had the potential to directly affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: On September 30, 2025, from approximately 12:20 p.m. to 2:35 p.m., the surveyor toured the facility with environmental services director (ESD)-G, maintenance lead (ML)-J and regional director of environmental services (RDES)-K. During the tour the surveyor observed the following: The railing near resident room B12 was damaged with a piece of metal bent out at the bottom of the rail. This hanging piece of metal could potentially catch on clothing or cut someone's hand while using the railing and should be removed. The railing should be maintained free of errant materials and in smooth, proper condition. ML-J and ESD-G acknowledged the noted deficiency during the tour and expressed that they would correct the deficiencies.	0 800		

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0 800	Continued From page 17 TIME PERIOD FOR CORRECTION: Seven (7) days	0 800		
0 810 SS=F	144G.45 Subd. 2 (b-f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) staff actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Staff of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for staff twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill.	0 810		

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0 810	Continued From page 18 This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to develop the fire safety and evacuation plan with required content. This had the potential to directly affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On September 30, 2025, at approximately 2:00 p.m., environmental services director (ESD)-G, maintenance lead (ML)-J and regional director of environmental services (RDES)-K provided documents on the fire safety and evacuation plan (FSEP), fire safety and evacuation training, and evacuation drills for the facility. The licensee FSEP failed to include the following: The FSEP failed to include appropriate employee actions to take during a fire or similar emergency. The FSEP contained employee actions for evacuation that were not specific to the building but were instead tailored for other buildings on the campus. The provided plans were written for the towers nearby and included information not relevant to the Benedict House for evacuation and may cause confusion in an emergency. RDES-K stated specific plans had not been	0 810		

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0 810	Continued From page 19 developed for the Benedict House for employee evacuation policies. The FSEP should include employee actions to be taken during a fire or other emergency that are relevant and accurate. The FSEP failed to include appropriate resident actions to take during a fire or similar emergency. The FSEP contained resident actions for evacuation that were not specific to the building but were instead tailored for other buildings on the campus. The provided plans were written for the towers nearby and included information not relevant to the Benedict House for evacuation and may cause confusion in an emergency. RDES-K stated specific plans had not been developed for the Benedict House for resident evacuation policies. The FSEP should include resident actions to be taken during a fire or other emergency that are relevant and accurate. During an interview on September 30, 2025, at approximately 2:30 p.m., the surveyor explained the requirements for site specific policies and FSEP documentation. ESD-G and RDES-K stated they understood the requirements. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	0 810		
01290 SS=F	144G.60 Subdivision 1 Background studies required (a) Employees, contractors, and regularly scheduled volunteers of the facility are subject to the background study required by section 144.057 and may be disqualified under chapter 245C. Nothing in this subdivision shall be construed to prohibit the facility from requiring self-disclosure of criminal conviction information.	01290		

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01290	Continued From page 20 (b) Data collected under this subdivision shall be classified as private data on individuals under section 13.02, subdivision 12. (c) Termination of a staff member in good faith reliance on information or records obtained under this section regarding a confirmed conviction does not subject the assisted living facility to civil liability or liability for unemployment benefits. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure two of 127 employees (unlicensed personnel (ULP)-L, ULP-M) were affiliated with the assisted living license as required. This had the potential to affect all residents residing within the facility. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: ULP-L was hired on July 18, 2023, to provide direct care services to the licensee's residents. ULP-L's employee record contained a background study dated July 5, 2023, for another health facility identification number (HFID#). ULP-L's record lacked evidence the licensee affiliated ULP-L's background study to their assisted living facility's HFID.	01290		

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01290	Continued From page 21 ULP-M was hired on January 8, 2024, to provide direct care services to the licensee's residents. ULP-M's employee record contained a background study dated July 28, 2025, for another health facility identification number (HFID#). ULP-M's record lacked evidence the licensee affiliated ULP-M's background study to their assisted living facility's HFID. On September 30, 2025, at 10:00 a.m., regional director of housing services (RDHS)-C indicated ULP-L and ULP-M were both employees who were assigned to work from a "sister" facility (HFID-20211) and had not been affiliated with this licensee's HFID-32176. On September 30, 2025, at 11:00 a.m., RDHS-C provided the surveyor with an updated NETStudy roster indicating all staff assigned to work at HFID-32176 had now been affiliated with the licensee. The licensee's Background Study policy dated November 20, 2024, indicated a background check will be completed for all community and Support Center associates, and for volunteers, students/interns, temporary staff, agency staff and independent contractors as set forth in this policy No further information was provided. TIME PERIOD FOR CORRECTION: Two (2) days	01290		
01760 SS=D	144G.71 Subd. 8 Documentation of administration of medication	01760		

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01760	Continued From page 22 Each medication administered by the assisted living facility staff must be documented in the resident's record. The documentation must include the signature and title of the person who administered the medication. The documentation must include the medication name, dosage, date and time administered, and method and route of administration. The staff must document the reason why medication administration was not completed as prescribed and document any follow-up procedures that were provided to meet the resident's needs when medication was not administered as prescribed and in compliance with the resident's medication management plan. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure medications were administered as ordered for one of ten residents (R2) receiving medication services. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R2 began receiving services under the facility's Assisted Living Facility with Dementia Care license on May 23, 2024, with diagnoses including Alzheimer's disease. R2's Service Plan dated November 21, 2104,	01760		

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01760	Continued From page 23 indicated she received services to include medication administration. R2's prescriber order dated October 14, 2024, included diclofenac (a topical medication for pain) 1% gel, 2 grams (gm) to right wrist four times daily. On September 29, 2025, at 11:34 a.m., the surveyor observed unlicensed personnel (ULP)-D to access R2's electronic medication administration record (EMAR) and remove R2's tube of diclofenac gel from the medication cart. ULP-D went to R2 seated at the dining room table and applied an undetermined amount of diclofenac gel to her gloved finger and applied the medication to R2's right wrist. ULP-D stated she usually used a pea sized amount of the medication for R2's wrist. On September 30, 2025, at 9:16 a.m., the surveyor observed ULP-F set up R2's oral medications and removed R2's tube of diclofenac gel from the medication cart. ULP-F then went to R2's room, administered R2's oral medications, and donned a pair of gloves. ULP-F then squeezed an undetermined amount of diclofenac gel to R2's right wrist. R2 rubbed the medication into her own wrist. The surveyor and ULP-F returned to the medication cart to return the diclofenac to the cart and document R2's medication administration. When asked about how much diclofenac gel ULP-F thought she administered, ULP-F stated, "I guess I don't know." When the surveyor and ULP-F looked for the diclofenac measuring tool, found in the box, ULP-F stated, "yes, I know about the tool, I have not been using it, I just eyeball it." ULP-D and ULP-F failed to use the proper	01760		

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01760	Continued From page 24 measuring tool to administer R2's diclofenac to the correct dose as ordered by the prescriber. On October 1, 2025, at 1:10 p.m., clinical nurse supervisor (CNS)-B stated the ULP are trained to use the specified measuring tool included in the diclofenac box to properly measure the dose as ordered. The licensee's Medication, Treatment, and Therapy Administration -Licensed and Unlicensed Personnel policy dated August 1, 2021, indicated medications, treatments, or therapies will be administered according to the "6 Rights": a. Right person b. Right medication c. Right time d. Right route (by mouth, eye drops, to the skin, etc.) e. Right dose (how many milligrams, drops, etc.) f. Right reason - Medication, treatment, or therapy will be administered as directed by the resident's Provider orders, the service plan and MAR. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days.	01760		
02410 SS=D	144G.91 Subd. 13 Personal and treatment privacy (a) Residents have the right to consideration of their privacy, individuality, and cultural identity as related to their social, religious, and psychological well-being. Staff must respect the privacy of a resident's space by knocking on the door and	02410		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	32176	A. BUILDING: _____ B. WING _____	10/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BENEDICT HOUSE	3883 19TH AVE NW ROCHESTER, MN 55901

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
02410	Continued From page 25 seeking consent before entering, except in an emergency or unless otherwise documented in the resident's service plan. (b) Residents have the right to have and use a lockable door to the resident's unit. The facility shall provide locks on the resident's unit. Only a staff member with a specific need to enter the unit shall have keys. This right may be restricted in certain circumstances if necessary for a resident's health and safety and documented in the resident's service plan. (c) Residents have the right to respect and privacy regarding the resident's service plan. Case discussion, consultation, examination, and treatment are confidential and must be conducted discreetly. Privacy must be respected during toileting, bathing, and other activities of personal hygiene, except as needed for resident safety or assistance. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to provide privacy for one of three residents (R1) during a treatment. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: On September 29, 2025, at 11:30 a.m., unlicensed personnel (ULP)-D brought R1 to the	02410		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	32176	A. BUILDING: _____ B. WING _____	10/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BENEDICT HOUSE	3883 19TH AVE NW ROCHESTER, MN 55901

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02410	Continued From page 26 dining room table in preparation for lunch. ULP-D completed R1's blood sugar check at the dining room table with two other residents also at the table. One resident seated next to him stated, "Poke him good, really good." On September 30, 2025, at 11:40 a.m., ULP-F completed R1's blood sugar check at the dining room table prior to lunch being served. Furthermore, there were three other residents seated at the table with R1 who watched the treatment. The licensee failed to ensure R1 was provided privacy during the treatment of his blood sugar check. On October 1, 2025, at 1:10 p.m., clinical nurse supervisor (CNS)-B stated she expected privacy with treatments, and blood sugar checks should be done in the resident's room. The licensee's Bill of Rights for Assisted Living Residents dated November 8, 2022, indicated "Residents have the right to respect and privacy regarding the resident's service plan. Case discussion, consultation, examination, and treatment are confidential and must be conducted discreetly. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	02410		

Rochester District Office
Minnesota Department of Health
3425 40th Avenue NW, Suite 115
Rochester, MN 55901
Phone: 651-201-4500

Food & Beverage Inspection Report

Establishment Info

BENEDICT HOUSE
3883 19TH AVENUE NW
Rochester, MN 55901
Olmsted County
Parcel:

Phone:

License Info

License: HFID 32176

Risk:
License:
Expires on:
CFPM: Kelsey Hechet
CFPM #: 125068; Exp: 9/2/2027

Inspection Info

Report Number: F1038251085
Inspection Type: Full - Single
Date: 9/30/2025 Time: 9:09:36 AM
Duration: 90 minutes
Announced Inspection: No
Total Priority 1 Orders: 0
Total Priority 2 Orders: 0
Total Priority 3 Orders: 3
Delivery: Emailed

New Order: 4-500 Equipment Maintenance and Operation
4-501.11AB *Priority Level: Priority 3 CFP#: 47*
MN Rule 4626.0735AB All equipment and components must be in good repair and maintained and adjusted in accordance with manufacturer's specifications.
COMMENT:
FACE PLATE ON CABINET IS MISSING.
Comply By: 10/7/2025 Originally Issued On: 9/30/2025

New Order: 4-900 Protecting Clean Items
4-901.11 *Priority Level: Priority 3 CFP#: 44*
MN Rule 4626.0935 Allow equipment and utensils to air-dry after cleaning and sanitizing; only use cloths that are clean and dry for polishing utensils that have been air dried.
COMMENT:
DISHED SET ON A CLOTH TO DRY
Comply By: 10/1/2025 Originally Issued On: 9/30/2025

New Order: 6-500 Physical Facility Maintenance/Operation and Pest Control
6-501.114AB *Priority Level: Priority 3 CFP#: 55*
MN Rule 4626.1580AB Remove all items unnecessary to the operation or maintenance of the establishment and litter from the premises.
COMMENT:
STOVE IN FACILITY NOT IN USE, NO PLANS TO USE ITEM
Comply By: 10/7/2025 Originally Issued On: 9/30/2025

NOTE: All new food equipment must meet the applicable standards of the American National Standards Institute (ANSI). Plans and specifications must be submitted for review and approval prior to new construction, remodeling or alterations.

I acknowledge receipt of the Rochester District Office inspection report number F1038251085 from 9/30/2025

Linda Jones
Food Service Director

Rob Davis,
Public Health Sanitarian 2

507-206-2757
rob.davis@state.mn.us